



Health Care Access for All

**California's 1115 Medicaid Waiver Renewal
Behavioral Health Integration Opportunities
April 2010**

The California Primary Care Association (CPCA) represents more than 800 not-for-profit community clinics and health centers¹ in California that provide comprehensive, quality health care services to primarily low-income, uninsured, and underserved Californians. As one of the few providers who open their doors to anyone regardless of their ability to pay, community clinics and health centers (CCHCs) play a critical role in assuring access to health care services in California, serving over four million patients each year. Nearly two-thirds of their patients have incomes below the federal poverty line, 83 percent live below 200 percent of poverty, and 49 percent speak a primary language other than English.

Community Clinics and Integration

As trusted health care homes for many underserved, ethnically and racially diverse individuals and families, CCHCs play a unique role in providing mental health services to those who may never seek out or have access to traditional mental health services. While safety net infrastructure differs greatly from community to community across California, in many places, primary care clinics have become the de-facto mental health system for individuals across the entire continuum of mental health need.

Individuals with acute mental health needs requiring short-term therapeutic or other interventions are often unable to access services through traditional mental health providers because they do not meet the eligibility requirements, so CCHCs have expanded their services to fill this unmet need. Other individuals may meet the criteria for care within the specialty mental health system, but due to capacity constraints are denied entry into the system. When services are available within the specialty mental health system, some individuals choose not to access them based on perceived stigma. For many minority communities there exists significant mistrust and fear of mental health treatment, as well as taboos and stigma around mental illness. Fortunately, stigma in seeing your primary care provider is practically non-existent, and when receiving care at a CCHC, you can expect the cultural diversity of the local community to be reflected in the staff.

For all of these reasons, and because many visits to primary care have psychosocial drivers, CCHCs have adopted the Integrated Behavioral Health Care Model, which seeks to most effectively care for patients' needs and support primary care providers by including behavioral health providers, such as psychologists and clinical social workers, as part of an interdisciplinary health care team. Keeping individuals in one system of care has been shown to improve health outcomes, especially for patients with chronic health conditions such as diabetes and hypertension.

Integration and the Health Care Home

Community clinics and health centers have always strived to be comprehensive health care homes for their patients and offering behavioral health services is part of this whole-person approach to care. In addition to primary and preventive care, CCHCs offer a comprehensive continuum of care to their patients that includes access to essential services on-site or by referral including oral health, behavioral health, substance use, and specialty care. These services are supplemented by a broad range of enhanced services that together ensure access to truly patient-centered care including outreach, case management, patient education, translation and interpretation, childcare, transportation vouchers, and assistance applying for health insurance coverage.

The comprehensive model used by CCHCs has been shown to provide high-quality and cost-effective care that reduces hospitalizations, emergency department visits, and costly care by specialists. Nationwide, compared with Medicaid patients treated elsewhere, Medicaid patients served at health centers are between 11 and 22 percent less likely to be hospitalized for avoidable conditions; 19 percent less likely to use the emergency room for avoidable conditions; and have lower hospital admission rates, shorter lengths of hospital stays, less costly admissions, and lower outpatient costs. Together, this amounts to 30-33 percent in total cost savings for each Medicaid beneficiary served in a community health center.²³

Unfortunately, the Medi-Cal program does not support many aspects of the health care home model. We will not be able to succeed with the current system of reimbursement which places barriers to integrated care by: not reimbursing health centers for both a mental health visit and a primary care visit on the same day, not reimbursing for the services of Marriage and Family Therapists (MFTs) when they make up the largest proportion of mental health providers in the state, denying coverage for the cost of case management services for our most complex patients, and limiting primary care providers' ability to reach patients beyond clinic walls, for example for outreach purposes or to work collaboratively and co-locate within County Mental Health settings.

There must be incentives that encourage care coordination and case management that can be delivered by a variety of appropriate staff to promote team-based care. In the CCHC setting, disease management and care coordination activities utilize a range of providers, from physicians and nurses, to health educators and medical social workers. However, provider organizations are generally not paid for non-physician caregivers to provide chronic care, preventing clinics from being able to properly support the critical work performed by other members of the multidisciplinary treatment team. Primary care physicians are often too busy to perform all chronic care functions themselves, fortunately many of these tasks can be well performed by non-physician members of a practice team, with the support of protocols, standing orders, oversight, and training. In fact, some aspects of chronic care—particularly monitoring and education—may be better performed by other team members if they have special skills or experience, such as language proficiency or other cultural sensitivity, or personal experience of the disease.

Some of the best practices in primary care based chronic care are not currently reimbursable at CCHCs. Medi-Cal should pay for components of the Chronic Care Model that have been shown by the research literature to be effective not only in improving health outcomes, but also in reducing non-ambulatory costs, such as hospitalization. Examples include: group visits, and

time spent entering data into and using disease registries for population management or preparing to maximize the value of an individual visit. Reimbursement for patient self-management training is especially critical. For chronic conditions, substantial segments of management are under direct control of the patient (such as diet and medication use). Self-management support involves helping patients and their families acquire the skills, confidence, and problem-solving techniques to manage their chronic illness. Through self-management coaching, patients become active participants in their treatment by setting realistic goals with their care providers for the day-to-day management of their disease.

Integration through Partnerships

As California's CCHCs continue to enhance their internal behavioral health capabilities to better serve their patients, there is still a need for strong partnerships and referral arrangements with the specialty mental health system to address the needs of individuals whose mental health conditions are not adequately addressed in all primary care settings. While growing, the Integrated Behavioral Health Care movement within primary care does not replace the role of the specialty mental health system in providing comprehensive treatment and supportive services for the most seriously mentally ill.

We must continue to look for opportunities to partner and leverage resources to best meet the needs of all individuals and families with behavioral health needs. Policy developed under the new waiver should allow for different collaboration models that leverage resources based on the capacity of local safety net providers. Many collaborative relationships exist between CCHCs and County Mental Health Departments; the waiver should serve as an opportunity to spread the best practices exhibited by successful CCHC/County Mental Health partnerships, and to reduce the barriers both parties face to working in a more integrated manner.

The Integrated Behavioral Health Project recently published the *Partners in Health: Primary Care / County Mental Health Tool Kit*, which lists various collaboration models in use in California for the State and stakeholders to consider:

- The county mental health agency out-stations mental health workers at primary care sites and/or county mental health agency contracts with select primary care providers to deliver health screening and basic services at mental health facilities.
- A county-run mental health clinic has a collaborative arrangement with a primary care clinic to provide health services for their clientele.
- County mental health makes assessment and triage services available to primary care providers.
- County mental health enters into an agreement with primary care providers to deliver services to stabilized clients with serious mental illness and, in return, offers support services, consultation and ease in transitioning the client back to the mental health system when needed.

Behavioral Health Integration Technical Workgroup Pilot Proposal

On Target Population

Due to the focus on achieving cost savings under the new waiver, there has understandably been a major focus at the technical workgroup on addressing the needs of individuals who fall into quadrants two and four of the National Council for Community Behavioral Healthcare's Four Quadrant Model. However, as safety net providers who see anyone that walks in the door, CCHC patients live in all four quadrants and the lines are not easily defined. While the State has expressed an interest in focusing on individuals with serious mental illness, many individuals end up progressing to serious illness due to the sizeable unmet need when a person falls into the gap between what primary care can offer and the threshold to enter the specialty mental health system. Even if the threshold is met, the capacity of the specialty mental health system to enroll more people is in many communities severely limited.

New resources made available under the next waiver for behavioral health integration efforts should be invested where there is the greatest opportunity for return on investment for the Medi-Cal program. While level of behavioral health need may be in some instances correlated with patterns of expensive and avoidable health care utilization, it would be irresponsible to assume all individuals with high behavioral health needs also require extensive medical care management, and/or ignore those with lower behavioral health needs who actually do.

As the data presented to the technical workgroup by JEN Associates on *Prioritizing High-Risk SMI Patients for Case Management/Care Coordination* demonstrates, there is a small subset of the SMI Medi-Cal population driving most of the costs. In their analysis of savings opportunities, it should be noted a key factor leading to recovery versus relapse was a higher ratio of physical to mental health expenditures, and for the low risk SMI population, a major indicator of continued health was access to the kind of preventive primary care and chronic disease management that is a forte of CCHCs.

On Aligning Incentives and Addressing Frequent Users

To achieve budget neutrality, care coordination under the waiver must correct the costly utilization pattern of patients seeking care in the hospital setting for conditions that could be treated more economically in primary care. However, programs delivering the kinds of services that proactively keep patients out of the hospital are rarely funded from the same budgets that pay for hospital care, making it difficult to incentivize a shift to outpatient, community-based care. Mechanisms should be established to recognize and reward health care homes for the hospital savings they produce. Integrated systems that encourage local safety net partnerships can help CCHCs and others to develop and achieve shared financial risk, resources, and financial accountability, as well as common medical records and quality standards.

On Substance Use

CPCA understands the technical workgroup has prioritized the practice of substance use screening and treatment in primary care settings, and agrees there is significant unmet need for

these types of services within the safety net. Many CCHCs already have some screening capability built into the primary care provider encounters that patients seek out to address other needs, but once identified there are often no treatment services offered within the community to refer patients for help. As SBIRT (Screening, Brief Intervention, and Referral to Treatment) programs have demonstrated, there are substance use interventions appropriately delivered within primary care, but current reimbursement streams do not support primary care practices in offering these critical services.

Given the implementation of federal mental health parity and health care reform looming, California could use the waiver as an opportunity to explore models of delivering substance use services within primary care that once proven could be instituted statewide. According to the Obama Administration's National Drug Control Strategy released in February 2010, enhancing substance use care in the primary care safety net will be a federal priority in the coming year, with \$25 million in FY 2011 dedicated to adding trained behavioral health counselors and other addiction specialists into federally qualified health centers (FQHCs). As with other funding opportunities available through the HRSA-run FQHC program, accessing these resources will likely be via competitive process. Through pilots in the new waiver, it may be possible to leverage this opportunity, positioning California to maximize the federal funds coming to the state for these purposes.

On the Health Care Coverage Initiative

On the topic of extending and expanding the Health Care Coverage Initiative (HCCI), CPCA has released a report, *Recommendations from Community Clinics and Health Centers on California's Health Care Coverage Initiative*, prepared by Alaina Dall, which provides an overview of the value of including CCHCs as strong partners in the HCCI as well as recommendations for increasing and securing the CCHC role. Community clinics and health centers will be vital to providing the increased access necessary to expand the program, so the waiver renewal should serve as an opportunity to remedy the uneven track record that counties have of contracting with CCHCs. One of the underlying challenges of the structure of the program was requiring counties to manage the program and budget without any guidelines as to how to involve other safety net providers in the community. As a result, patients suffer because they do not have a choice of providers and cannot select the practice setting in which they prefer to receive care, even if that clinic is the only one near their home. In these situations, the programs fail to strengthen relationships between safety net providers and an opportunity is missed to improve the safety net overall.

Assuming additional federal funds are made available under a next iteration of the HCCI, adding mental health and substance use services into the standard benefit package of the HCCI could strengthen the program in terms of responding to the diverse needs of medically indigent adults (MIAs). But resources will remain greatly limited with respect to need, and ultimately trade-offs will need to be made between expanding enrollment and enhancing services for enrollees. While county MIA spending will serve as the state match, to truly achieve the goal of extending coverage to as many MIAs as possible, current patterns of spending should not preclude the

funds acquired via federal match from benefiting MIA populations who currently do not access services or receive services outside the county health system.

Looking Ahead

CPCA looks forward to working with the State and fellow stakeholders to maximize the opportunity that this waiver renewal presents to prepare California for successful implementation of federal health care reform and mental health parity. CPCA encourages the Department of Health Care Services and the Legislature to explore how California can take advantage of the new state option included in the federal health care reform law, effective January 2011, to provide health homes for enrollees with chronic conditions who designate a provider or a team of providers, as a health home.

In this vein, CPCA has released a concept paper, *Community Clinics and Health Centers: Developing an Enhanced Primary Care Medical Home*, in support of a meaningful and vigorous demonstration of the medical/health home concept in California's next 1115 waiver. Around the country, CCHCs are at the center of many of the existing medical home demonstrations, including the demonstration announced by CMS at the end of 2009 for FQHCs and Medicare. California's CCHCs are one of the logical partners for a medical home demonstration and CPCA believes that the new waiver offers the opportunity to model and refine medical home concepts with existing safety net providers who are the primary providers of services for Medi-Cal beneficiaries. The Medicaid waiver and the health care reform provision mentioned above are opportunities to model medical homes that reflect the specific and diverse needs of subgroups of the Medi-Cal population, including the various categories of seniors and persons with disabilities with chronic illnesses, behavioral health and other special needs.

For further information, please contact Allison Homewood, Senior Healthcare Analyst, at ahomewood@cpc.org or 916.440.8170.

¹ Community clinics and health centers are those nonprofit, tax-exempt clinics that are licensed as community or free clinics, as defined under Section 1204 of the California Health and Safety Code, and provide services to patients on a sliding fee scale basis or, in the case of free clinics, at no charge to the patients. The term "CCHCs" includes federally designated community health centers, migrant health centers, rural health centers, and frontier health centers. Clinics meeting federal requirements and definitions for purposes of Medicaid reimbursement may also be referred to as federally qualified health centers (FQHCs) or FQHC look-alikes.

² Falik, et al. Comparative Effectiveness of Health Centers as Regular Source of Care (2006) Journal of Ambulatory Care Management. 29(1):24-35.

³ Duggar BC, et al. Utilization and Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers. Center for Health Policy Studies, 1994.